Appendix G

East Central Trauma Care Region Trauma Plan

EAST-CENTRAL MISSISSIPPI

TRAUMA CARE REGION

TRAUMA PLAN

Trauma Plan for the East-Central Mississippi Trauma Care Region approved this 7th.day of July, 2004.

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Chairman, Board of Directors

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Medical Director, East-Central Region

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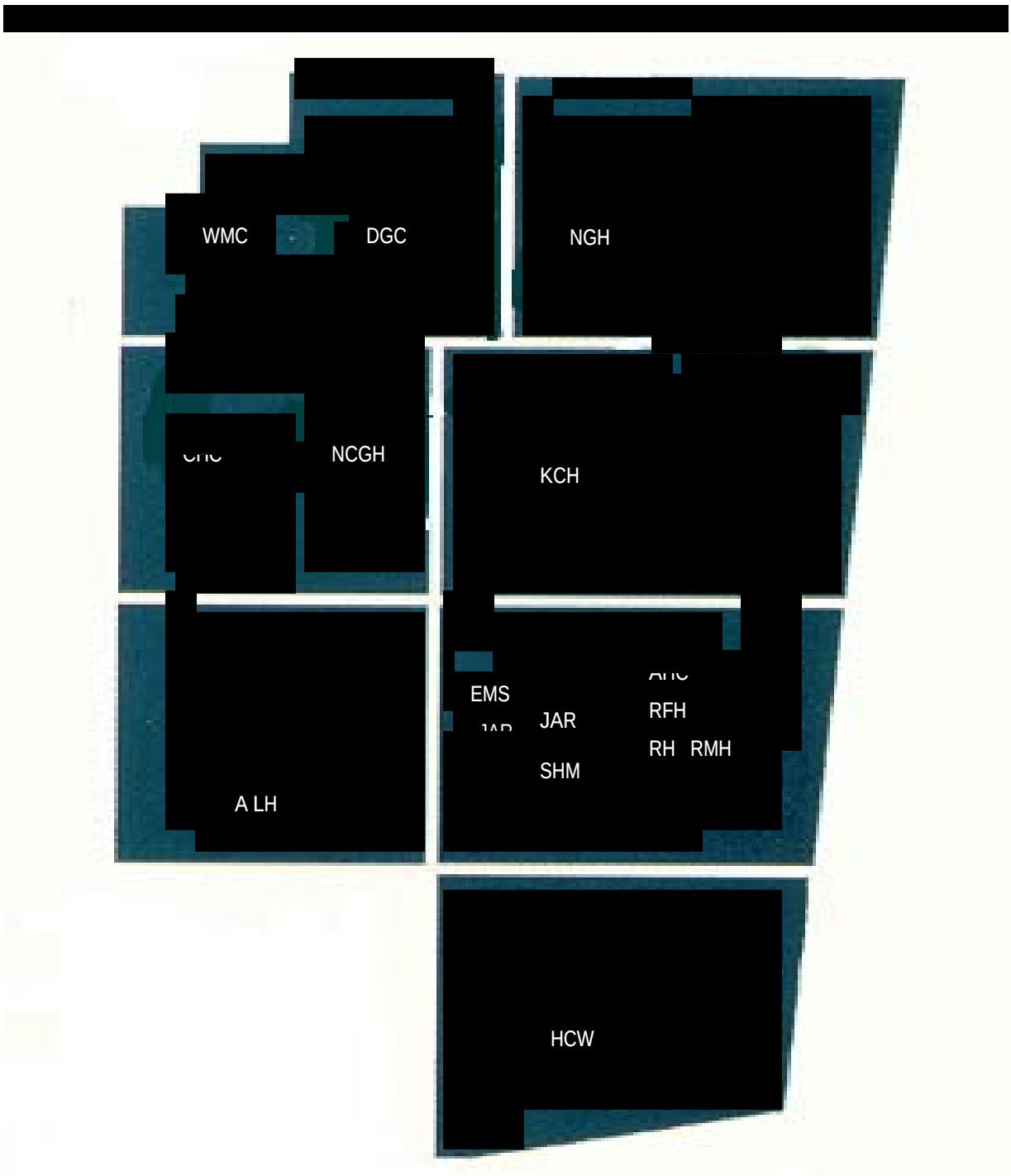

EAST-CENTRAL MISSISSIPPI TRAUMA CARE REGION

I. PARTICIPATING HOSPITALS

WMC	Winston Medical Center, Louisville
CHC	Choctaw Health Center, Choctaw
NCGH	Neshoba County General Hospital, Philadelphia
ALH	Alliance Laird Hospital, Union
NRH	Newton Regional Hospital, Newton
RMH	Riley Memorial Hospital, Meridian
HCW	H. C. Watkins Hospital, Quitman

II. NON-PARTICIPATING HOSPITALS

NGH	Noxubee General Hospital, Macon
RFH	Rush Foundation Hospital, Meridian
JAR	Jeff Anderson Regional Medical Center, Meridian

III. INELIGIBLE HOSPITALS

KCH Kemper Community Hospital, DeKalb-Closed

IV. LONG-TERM ACUTECARE HOSPITALS

RH Regency Hospital, Meridian
SHM Specialty Hospital of Meridian, Meridian

V. PSYCHIATRIC HOSPITALS

DGC Diamond Grove Center, Louisville
AHC Alliance Health Center, Meridian
EMS East Mississippi State Hospital, Meridian

(Revised 7/7/04)

PLAN SUMMARY

Trauma remains the leading cause of death and disability in the first four decades of life; and with an increasingly older population, it is becoming a major problem at older ages as well. In recognition of this fact, the state of Mississippi has chosen to legislate, and provide funding for, a statewide Inclusive Trauma Care System. This System, though voluntary, impacts upon all aspects of the trauma care apparatus in the State as well as upon virtually all hospitals, both designated and non-designated. The intention, of course, is to improve the quality of trauma delivered throughout Mississippi and to establish standards of excellence for the delivery of such care.

The State of Mississippi has been divided into seven Trauma Care Regions of varying sizes and geographical distribution (see map on page 1). The East-Central Mississippi Trauma Care Region (see map on page 2) encompasses the following counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Noxubee, and Winston. Presently, seven hospitals are participating in the East-Central Region: Newton Regional Hospital in Newton, Choctaw Health Center in Philadelphia, Neshoba County General Hospital in Philadelphia, H.C. Watkins Hospital in Quitman, Winston County Medical Center in Louisville, Alliance Laird Hospital in Union, and Riley Memorial Hospital in Meridian. The non-participating eligible hospitals in the Region are Noxubee General Hospital located in Macon in Noxubee County, Jeff Anderson Regional Medical Center and Rush Foundation Hospital, which are both in Meridian in Lauderdale County.

The East-Central Region was organized and incorporated in January 2000. It was officially designated as the East-Central Trauma Care Region, Inc., on February 29, 2000. A Board of Directors was elected, Bylaws drafted and approved, and organizational activities begun.

The mission of the East-Central Region is multifold. First and foremost, the Region is committed to improving the level of trauma care throughout the Region as well as throughout the state as a whole. To this end, requirements, which at times exceed the expectations of the Statewide Trauma System, have been made of the member hospitals. It is felt, however, that in order to improve the quality of trauma care delivered—especially in rural centers—such "desirable" attributes as ATLS certification for all physicians directly involved in trauma care should be made mandatory. Therefore, the East-Central Region has expanded the requirements for member hospitals beyond the minimums set by the State. Second, major emphasis in this Region is upon trauma education. Therefore, a large part of the annual budget is dedicated to funding ongoing CME activities, conferences, and workshops in order to maintain a high level of academic excellence with regard to trauma. These activities are provided to member hospitals free-of-charge, but the understanding is that those hospitals and their personnel will continue to play an active role in the Mississippi Trauma Care System. Third, it is felt that a vital part of the mission of the East-Central Region should be outreach. It is only by sharing resources and reaching out and coordinating with other hospitals outside the East-Central Region that a cohesive, truly inclusive Trauma System can be developed. Therefore, invitations have been sent to other prospective-Level IV centers to join in the educational programs sponsored by the East-Central Region.

The bulk of the East-Central Region is rural, and all participating hospitals to date are all Level IV designees. It follows that resources among the member hospitals will vary considerably. There is a certain amount of latitude in the requirements for Level IV Centers. The Regional Plan must, therefore, reflect this diversity, as well as the fact that resources at smaller, rural hospitals are often severely limited. An attempt has, therefore, been made to develop general guidelines and strategies for dealing with such issues as field triage, pre-hospital care, and trauma team activation. Flexibility has been written into the Plan so that individual hospitals may make their own decisions regarding issues with local or regional complicating factors. Some oversight is required, however, in order to assure a uniform and acceptable standard of practice throughout the Region. Mandatory regional policies have, therefore, been developed to provide this uniformity and oversight.

OBJECTIVES

In brief, the purpose of the East-Central Regional Trauma Plan is to provide a framework for the development of a cohesive System throughout the East-Central Region and to improve the quality of trauma care in East-Central Mississippi. To this end, the following objectives have been established:

1. Plan Development

   Development of the Regional Trauma Plan is a requirement of membership and participation within the Mississippi Trauma Care System. Guidelines for regional plan content were provided by the State to assist the Region with adherence to State-established criteria. An objective of the East-Central Trauma Region is to develop our Regional Plan using those guidelines. Dr. Jack Sariego, previous East-Central Trauma Regional Chairman, drafted the initial Plan. Open discussion was conducted on the Plan by Regional Board members. Revisions were drafted, and the Plan was approved by the Board. The Plan was submitted to the State in November 2000. The State, through the work of out-of-State consultants, provided the Region with an editorial review of the Plan in May 2001. Regional Board member volunteers drafted additional revisions to the Plan. The revised Plan was approved by the Board in September 2001 and submitted to the State.

2. Commitment to Ongoing Participation and System Ownership

The long-term viability of the East-Central Trauma Region will be predicated on widespread Regional commitment to ongoing participation and a sense of member ownership. Member hospitals have submitted letters to the Region confirming their ongoing commitment to the Trauma System (see Documentation of Participation, page 26). An objective of the East-Central Trauma Region is to promote and enhance Regional participation and sense of ownership. To this end, the Region has been developed by its members with input from each member, so that each member has a stake in the design and implementation of the Regional System. Our anticipated outcome of this objective is the sustained membership of all eligible hospitals within the Region. The outcome will be measured by Regional membership.

3. Inclusive Nature of the Plan with Universal Access

The East-Central Trauma Region is one of seven regions designed to provide trauma coverage for the entire State of Mississippi. By nature and design, the Regional Plan is an integral part of a whole and should be designed to be inclusive. An objective of the East-Central Trauma Region is to develop an inclusive system, both with the Region and within the State. Our anticipated outcome of this objective is to provide a trauma system that will provide a comprehensive network for trauma care accessible by every resident of the Region. The outcome will be measured by the Region's ability to coordinate an integrated system from pre-hospital emergency management services to appropriate level hospital services to post-trauma rehabilitative services if necessary.

4. Public Education

Public education has proved to be the most effective means of reducing trauma-related injuries and deaths. With the implementation of a trauma system the Region, through its trauma registry, will have the ability to track and quantify trauma-related information. This data can then be used to educate the public proactively to prevent and reduce trauma-related injuries. An objective of the East-Central Trauma Region is to use trauma registry information to identify high-incident, trauma-related injuries and develop a public awareness and educational program in an effort to prevent and reduce these injuries. Our anticipated outcome is the reduction of identified and targeted trauma injuries through public education. This outcome will be measured by utilizing ongoing trauma registry reporting to evaluate the impact of Regional public education affects on targeted trauma injuries.

5. Quality Medical Care and Performance Improvement

The primary goal of any trauma system, and the goal of the Mississippi Trauma Care System in particular, is to improve the outcome of acutely injured patients. An emphasis on performance improvement is essential to this end. Ongoing performance improvement on Regional trauma issues will be an integral part of Regional Board meetings. An objective of the East-Central Trauma Region is to continually strive for quality medical care through performance improvement. The anticipated outcome of this objective is enhanced quality medical care. This outcome will be measured by results reported through the performance improvement process.

6. Research and Future Plans

A Trauma Plan is dynamic and will necessarily change as a new and deeper understanding develops regarding the most efficient and appropriate method for delivering trauma care. An objective of the East-Central Trauma Region is to continually research and evaluate trauma care within the Region and improve the future of trauma care delivery. The anticipated outcome of this objective is a dynamic, not static, Trauma Plan. This outcome will be measured by the continued relevance and effectiveness of the Plan.

IMPLEMENTATION SCHEDULE

The East Central Trauma Region was organized almost four years ago. Therefore, several elements of the Regional Plan, particularly administrative structure and trauma level designations, have been implemented and are operational. However, for the most part, member hospitals have been functioning independently within the Region. For the member hospitals to truly function as a Region, the following items have been identified for implementation.

ELEMENT	START DATE	COMPLETION DATE
1. Regional Trauma Registry		
A. Regional Registry Data Management Use of Regional Registry data for Regional performance improvement activity	10/01	Ongoing

ELEMENT	START DATE	COMPLETION DATE
4. Education		
A. Public Education Injury prevention and reduction based upon regional trauma data collection and identification; coordinate education effort with other agencies and medical facilities	07/02	Ongoing

ADMINISTRATIVE STRUCTURE

The East-Central Mississippi Trauma Care Region is comprised of seven counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Noxubee, and Winston. At present, seven hospitals are active members of both the Region and of the Mississippi Trauma Care System: Newton Regional Hospital in Newton, Choctaw Health Center in Choctaw, Neshoba County General Hospital in Philadelphia, H.C. Watkins Hospital in Quitman, Winston County Medical Center in Louisville, Alliance Laird Hospital in Union, and Riley Memorial Hospital in Meridian. The eligible, non-participating hospitals are Noxubee General Hospital in Macon and Rush Foundation Hospital and Jeff Anderson Regional Medical Center in Meridian in Lauderdale County.

The East-Central Region is governed by a Board of Directors comprised of the following: a medical representative from each member hospital, an administrative representative from each member hospital, an EMS representative elected by the Board of Directors (see Regional Board General Policies/Bylaws below). Officers are elected from the Board, with all members except the EMS representative eligible for office.

The Chairman of the Board of Directors serves as Executive Director for the Region. If the Chairman is a physician, the he will also serve as Medical Director for the East-Central Region. If the elected Chairman is not a physician, then a separate Medical Director will be named by the Board.

The Regional Board of Directors, through their Chairman, will work collaboratively with their peers in the adjoining Regions to insure continued coordination of policies, procedures, and protocols.

The Region receives funds from the State to finance the administration of the Region. The Region approves and submits an annual budget to the State. Use and distribution of funds are approved by the Regional Board of Directors and documented in Board minutes. Financial accounting records are kept by a subcontracted Administrative Assistant. Monthly financial statements are routinely prepared and submitted to the Board for approval.

A subcontract arrangement was made with Newton Regional Hospital in Newton, MS, to provide an Administrative Assistant at 0.5 FTE. In addition, office space and utilities are provided by Newton Regional Hospital and are reimbursed on a monthly basis by the Region. Newton was chosen as the administrative center for the East-Central Region because of its subcontract arrangement with the Region.

EAST-CENTRAL MISSISSIPPI TRAUMA CARE REGION

REGIONAL ORGANIZATIONAL CHART

BOARD OF DIRECTORS

EXECUTIVE DIRECTOR/
MEDICAL DIRECTOR

EXECUTIVE COMMITTEE

BOARD FUNCTIONS AS A WHOLE

Performance Improvement
Public Information
Data Collection
Data Evaluation
Trauma Education
Outreach
Fiscal Duties

MEDICAL ORGANIZATION AND MANAGEMENT

The seven counties in the East-Central Trauma Care Region comprise a block of adjacent counties in east-central Mississippi. There is one major city of moderate size in the Region (Meridian), and all of the member hospitals are Level IV facilities scattered throughout the Region. Currently, on-line Medical Control for the member hospitals is provided through the Central EMS District in Jackson.

The East-Central Regional Trauma System is an inclusive one with each member hospital playing an equal and unique role in policy establishment, implementation, and oversight. Each member hospital is represented equally on both the full Board of Directors. Though each hospital is required to independently develop its own in-house Trauma Program, it is expected that each will follow the guidelines set forth by the Regional Plan with regard to pre-hospital trauma triage, inter-hospital transfer, and trauma diversion.

INCLUSIVE NATURE OF THE TRAUMA SYSTEM

As mentioned above, the intent of the East-Central Regional Trauma System is that it be inclusive and all encompassing. This requires that it address all issues related to Trauma care, from the pre-hospital providers to transfer arrangements among hospitals. In addition, the Regional Plan must address the fact that some of the hospitals within the East-Central Region are non-participating and, therefore, technically outside of the control of the Region. Nevertheless, cooperation with these non-member hospitals is essential if the System is to work efficiently.

Inclusion

All hospitals within the counties encompassed by the East-Central Region are eligible for membership in the Region. Refer To map of the East Central Region Hospitals (page 2) for identity and location of regional providers. Refer to Resource Allocation (page 38) for trauma level designations and capabilities of individual hospitals. All hospitals in the Region will be encouraged to participate at an appropriate level. Even though a hospital does not formally participate in the System, it will still be affected by Regional regulations and controls. Most importantly, non-member hospitals will be affected by the guidelines regarding pre-hospital triage and transfer. As discussed below, triage guidelines are <u>not</u> solely or predominantly based upon membership in the East-Central or Mississippi State System; rather, these guidelines are based upon the most expeditious method of dealing with the acutely injured patient, as described by the American College of Surgeons Committee on Trauma and other governing bodies. Furthermore, transfer to a higher-

level Trauma Center will be governed by the Regional Inter-Hospital Transfer Policy. This will hold true within the East-Central Region regardless of whether or not the transferring facility is a member. Enforcement of this policy will essentially and realistically be at the receiving end, since a Trauma Center will have no System-sanctioned responsibility to accept a patient from a non-member hospital with which it does not have a Transfer Agreement and which does not meet Regional standards. In the absence of such an Agreement, and without the weight of the Trauma System behind it, the transferring non-member hospital may find itself in a situation in which it is unable to transfer an injured patient quickly and expeditiously to a definitive care facility. It is felt that the potential for this type of situation—and the attendant prospective harm to the patient—will compel non-member hospitals to seek membership in the Region in the future. Certainly, it is not the intent of the East-Central Regional Plan nor the Mississippi Trauma Care System to deny care to any patient; but a statewide standard *must* be the ultimate goal if a truly beneficial System is to be established.

Pre-Hospital Providers

It is acknowledged that there is no single pre-hospital provider within the East-Central Region. Each member hospital has an agency which is its primary provider, and these agencies differ throughout the Region (see Pre-hospital Providers listing below). Only Choctaw Health Center and Neshoba General Hospital in Philadelphia have their own ambulance service. The East-Central Regional Trauma Triage Policy is specific enough to establish firm guidelines for field triage but general enough to encompass all carriers and geographic locations within the Region.

EAST-CENTRAL MISSISSIPPI
TRAUMA CARE REGION

PRE-HOSPITAL PROVIDERS
(MOST-COMMONLY USED)

NEWTON REGIONAL HOSPITAL	Emergystat
NESHOBA CO. GENERAL HOSPITAL	Neshoba EMS
CHOCTAW HEALTH CENTER	CHC Ambulance
ALLIANCE LAIRD HOSPITAL	Emergystat
H.C. WATKINS MEMORIAL HOSPITAL	Para-tech Ambulance Service Enterprise Vol. FD Amb. Serv.
WINSTON MEDICAL CENTER	Emergystat
JEFF ANDERSON REGIONAL MEDICAL CENTER	Metro Ambulance Service
RILEY MEMORIAL HOSPITAL	METRO
RUSH FOUNDATION HOSPITAL	METRO
NOXUBEE GENERAL HOSPITAL	Emergystat
KEMPER	Emergystat

Inter-Regional Interactions

It is essential that lines of communication and interaction remain open with other adjacent Regions. Such interaction is important for several reasons. First, and most importantly, the Mississippi Trauma Care System is intended to be an *inclusive* System. This means that in order for the State to function as an integrated unit, all seven Regions must share information and resources so that no single Region is unable to provide a service for an injured patient. Second, from a practical standpoint, interaction with other Regions is necessary if a patient requires transfer to a higher-level facility. A policy has been established for inter-hospital transfer within and outside of the East-Central Region and will be binding on member hospitals. As previously discussed, realistically, this policy will also affect non-member hospitals, since their ability to transfer patients out of their institutions will depend in large part on the Trauma Center's willingness to accept those patients. This, in turn, will be determined in large part by the degree to which the transferring, non-member facility meets accepted Regional and Statewide standards of trauma care. Third, a major emphasis in the East-Central Region will be placed upon continuing trauma education and outreach activities. Courses, seminars, workshops, and symposia have and will continue to be established for member hospitals; but the outreach effort also requires the sharing of such educational opportunities with hospitals outside of the Region (see Outreach page 43). Finally, inter-Regional communication is an important component of each Region's Performance Improvement effort, since one barometer of a Region's improvement with regard to trauma care delivery is the degree to which it compares favorably with care delivered elsewhere in the State.

INTERFACILITY TRANSFER AGREEMENTS

None of the hospitals in the East-Central Region has the capability to provide comprehensive care to Trauma patients who present to their Emergency Departments. In fact, most of the member hospitals transfer the majority of their trauma patients to other facilities. In addition, resources are severely limited at many of these member hospitals (as they are in most of the Level IV Centers throughout the state). Therefore, it is essential that valid Transfer Agreements exist between hospitals to facilitate transfer of appropriate patients. These Agreements need not necessarily be with member Trauma Centers only. Nevertheless, each member hospital is responsible for maintaining current, active Transfer Agreements with other hospitals which can provide services not available at the member hospital (e.g., burn care, care of the multiple-injury patient, rehabilitation). These Agreements must be recorded with the Region and maintained as active.

A Policy for Inter-Hospital Transfer of High-Risk Patients has also been established for the East-Central Region and is binding on all member hospitals. This policy provides guidelines for the definition of a high-risk trauma patient and identifies those patients who would likely benefit from transfer to a higher-level facility.

The Trauma System is not designed to necessarily encourage lateral transfer of a trauma patient from a Trauma Center to a Center of equivalent level. However, within the East-Central Trauma Care Region, there are different categories of Trauma Centers. Therefore, it would not be

inappropriate in certain circumstances for a Level IV Center *without* surgical capability to transfer a patient to another Level IV Center *with* surgical capabilities within the same Region. This arrangement would of course be made physician-to-physician and would be based upon expanded capabilities at the receiving hospital, but such a transfer—under such circumstances—would not be discouraged. In fact, such cooperation is vital if the limited resources within the East-Central Region are to be utilized to their greatest advantage. Such redirecting of the injured patient may also occur at the pre-hospital level since the Trauma Triage Policy clearly mandates transport to the nearest *appropriate* facility, and the definition of "appropriateness" is certainly in large part determined by availability of resources such as surgical capabilities.

Since there is no advanced-level Pediatric Trauma Center within the East-Central Region, an active Transfer Agreement must be maintained between the member hospitals and the University Medical Center, which is currently the only such facility in the State. A separate Transfer Agreement is not required by the Region since pediatrics is included in the existing Agreement with UMC. Triage and transfer criteria will remain the same with pediatric patients as they are with adult trauma patient.

EAST CENTRAL MISSISSIPPI TRAUMA CARE REGION
TRANSFER PATTERNS

PATIENTS ROUTINELY TRANSFERRED

	NEWTON REGIONAL HOSPITAL	CHOCTAW HEALTH CENTER	NESHOBA CO GENERAL HOSPITAL	ALLIANCE LAIRD HOSPITAL	H.C. WATKINS MEMORIAL HOSPITAL	WINSTON MEDICAL CENTER	RILEY MEMORIAL HOSPITAL
Surgical	XX	XX	SOME	SOME	SOME	XX	
Orthopedic	XX	XX	XX	XX	XX	XX	
Neurosurgical	XX	XX	XX	XX	XX	XX	SOME
Burns (Severe)	XX	XX	XX	XX	XX	XX	XX
Burns (Minor)						XX	
Ophthalmology	XX	XX	XX	XX	XX	XX	
Multiply-Injured	XX	XX	XX	XX	XX	XX	

DOCUMENTATION OF PARTICIPATION

Each member hospital has submitted a letter to the Mississippi Department of Health attesting to its desire to participate in the Mississippi Trauma Care System. These letters have been signed by both an administrative representative for the hospital and a physician signatory representing the Medical Staff of each individual hospital. In addition, the East-Central Region has required each member hospital to file a letter with the Regional office attesting to its desire to participate in the East-Central Trauma Care Region. Similar documents will be required of each hospital that joins the Region in the future.

Hospitals participating as members of the East-Central Trauma Care Region are:

Newton Regional Hospital (Newton, MS)

Choctaw Health Center (Choctaw, MS)

Neshoba County General Hospital (Philadelphia, MS)

H.C. Watkins Hospital (Quitman, MS)

Winston County Medical Center (Louisville, MS)

Alliance Laird Hospital (Union, MS)

Riley Memorial Hospital (Meridian, MS)

OPERATIONAL IMPLEMENTATION OF POLICIES

The following policies have been developed by the East-Central Trauma Care Region, approved by the Board of Directors, and are considered binding on all member hospitals within the East-Central Region.

Trauma Triage Policy: establishes trauma triage criteria within the Region and sets standards for all injured patients to be triaged, treated, and transported to the closest, most appropriate level of care.

Policy for Inter-Hospital Transfer of High-Risk Trauma Patients: establishes criteria that may be used as Emergency Department guidelines for considering transfer of an injured patient to a higher-level Trauma Center.

Trauma Diversion Policy: establishes necessary and sufficient criteria for closing the Emergency Department of a member hospital to Trauma.

East Central Mississippi Trauma Care Region, Inc.

Trauma Triage and Transport Guidelines

Purpose: To provide EMS Agencies operating within the East Central Mississippi Trauma Care Region with general guidelines for prehospital triage and transport of the trauma patient.

A. The following criteria are recommended guidelines for activation of the Regional Trauma System. These criteria were adopted by the East Central Mississippi Trauma Care Region as general guidelines for activation of the Trauma Center Trauma Team and should therefore be used as a tool in identifying the major or multiple-injury trauma patient:

1. Glasgow Coma Scale. (GCS) <14
2. Systolic Blood Pressure <90 mm Hg
3. Respiratory Rate< 10 or >29
4. Penetrating injury to the head, neck, torso, or extremities above the elbows or knees
5. Flail chest
6. Two or more proximal long bone fractures
7. Pelvic fracture.
8. Limb paralysis
9. Amputation proximal to the wrist or ankle
10. Body surface burns> 15% (second or third degree) or burns associated with other traumatic or inhalation injury

11. Trauma transfer that is intubated or receiving blood
12. Children under l2 with any of the historical flats outlined below

- If none of the above apply, evaluate mechanism (Stable patient> 12 year. old)

1. Ejection from vehicle
2. Death in same passenger compartment
3. Extrication time> 20 minutes
4. Fall >20 feet
5. Rollover MVC
6. High speed auto crash>40mph
7. Auto' deformity> 20 inches of external damage or intrusion into passenger compartment > 12 inches
8. Auto vs. pedestrian or Auto vs. bicycle (> 5mph)
9. Pedestrian thrown or run over
10. Motorcycle crash' 20 mph or separation of rider from the bike

B. Trauma Patients with the following conditions should be transported to the closest appropriate hospital:

- Cardiac Arrest
- Nonpatent airway

- Hemodynamic compromise indicated by deteriorating vital signs

Patient and or family request will be considered, however hospital selection is determined by the EMS Provider and on-line Medical Control according to the above guidelines and is based entirely in the best medical interest of the patient.

If the Paramedic/EMT has any doubt as to whether a patient is a major trauma victim, he/she should consult with Medical Control and / or the receiving trauma facility at the earliest stage possible in the patient's evaluation.

C. EMS agencies shall immediately notify the receiving facility of impending arrival of Trauma Patients in order that the receiving facility can determine the number and type of patients they are capable of managing at that particular time.

D. Trauma Center Diversion/Bypass

   - Any Trauma Center going on or off Diversion shall notify EMS Dispatch immediately.

E. Prior to EMS crew departure, Patient Care Reports should be left at the receiving facility for ALL trauma patients, with documentation from time of dispatch until time of report at receiving facility.

East Central Mississippi Trauma Care Region

Performance Improvement Plan
For
Emergency Medical Services

I. PURPOSE

The purpose of the pre-hospital record audit is to establish a method of evaluation for the pre-hospital care being delivered, and thus be able to establish benchmarks as goals for improvement. Data from agencies within the East Central Trauma Care Region will be collected, organized and evaluated and the results utilized for continued system improvement. As the Performance Improvement evaluation continues, changes will be implemented in the plan, especially in the area of goals and indicators. Feedback will be provided to EMS agencies, as this is an important aspect of quality improvement. Results of the evaluations will also be made to the State office, as well as the East Central Trauma Care Region Board of Directors.

II. POLICY

EMS agencies will be required to provide audits on a quarterly basis. Prior to each quarter, agencies will receive a request from the Regional Administrator listing specific filters (indicators) with which to assess records for the upcoming quarter. This report should be returned to the administrator within 30 days. Indicators requested will be not less than four (4), nor more than six (6) for one quarter. Additionally, there may be a random request for a specific filter if there is a need indicated, or if it is requested by the Board of Directors.

III. PROCEDURE

Attached is an appendix with a list of indicators from which the administrator will choose four (4) to six (6) per quarter. Letters will be sent out to each EMS agency in the Region at least 14 days in advance with the specific indicators for the following quarter. The audit should be completed and returned to the administrator with 30 days of the end of the quarter.

IV. CORRECTIVE ACTION

In order to reduce variations of care, once problems are identified, the EMS Agency will be asked to submit a plan to correct identified problems. The plan should include what the desired changes are, who is assigned to resolve the problem, and what action will be taken. Mississippi EMS statutes (§41-59-9, *Mississippi Code Annotated)* mandate pre-hospital providers' compliance with this Trauma Plan, including these Performance Improvement policies and procedures. Noncompliance with this policy will be considered a violation of Mississippi law and EMS Rules and Regulations and will be reported to The Division of EMS, MSDH for administrative enforcement.

V. RE-EVALUATION

Three months after the corrective action plan has been submitted, the problem identifier will be re-evaluated. The EMS agency will receive documentation of any findings, as well as any need for continued action.

VI. CONFIDENTIALITY

The East Central Trauma Care Region will abide by the laws of the State of Mississippi regarding confidentiality. Patient names or other identifying criteria will not be used in reports or audits that are distributed to the Board of Directors or the State. Any records received by the administrator shall be stored under lock and key until destroyed.

APPENDIX A

RECOMMENDED EMS Audit Indicators

1. IV lines established where attempted
2. Intubation established where attempted
3. A scene time < 10 minutes (except in prolonged extrication)
4. Vital signs complete
5. Hospital destination appropriate
6. GCS recorded in categories
7. Pediatric Coma Score recorded in categories
8. RTS recorded
9. Emergent calls dispatched within 60 seconds
10. Length of time between Dispatch times and Arrival times for transfers out (hospital to hospital)
11. If patient in EMS care longer than 15 minutes, additional sets of VS documented
12. O2 use documented
13. Timely pre-arrival communication with receiving hospital
14. Documentation that written report left at health care facility with patient
15. Compliance with regional trauma guidelines and protocols
16. Any Bypass or Diversion orders/protocols initiated

POLICY FOR INTER-HOSPITAL TRANSFER

OF HIGH-RISK TRAUMA PATIENTS

PURPOSE: To establish criteria that may be used as Emergency Department guidelines for considering transfer of an injured patient to a higher-level Trauma Center.

PRINCIPLES: Criteria identified by the American College of Surgeons Committee on Trauma for identifying those patients at significant risk of mortality or major morbidity may serve as guidelines for regional Emergency Departments.

Consideration should be given to transferring acutely injured patients to a facility that provides a higher level of trauma care if any of the following criteria are met:

A. Penetrating injury to the head or open skull fractures
B. Depressed skull fractures
C. Glasgow Coma Score < 14 or GCS deterioration
D. Signs of lateralization
E. Suspected spinal or major vertebral injury
F. Significant Chest Injury
    a. Major chest wall injury
    b. Widened mediastinum or other signs of great vessel injury

c. Major cardiac injury

d. Patients requiring prolonged ventilation

G. Significant Pelvic Injury

a. Unstable pelvic ring disruption

b. Unstable pelvic fractures with shock or evidence of hemorrhage

c. Open pelvic injury

H. Major Extremity Injuries

a. Fracture/dislocation with loss of distal pulses

b. Open long-bone fractures

c. Extremity ischemia

I. Multiple System Injury

a. Head injury combined with face, chest, abdominal, or pelvic injury

b. Burns with associated injuries

c. Multiple long-bone fractures

d. Injury to more than two body regions

J. Co-Morbid Factors (associated with injury)

a. Age < 15 or > 55 years of age

b. Cardiac or respiratory disease

c. Insulin-dependent diabetes

d. Morbid obesity

e. Pregnancy

f. Immunosuppression

K. Secondary Deterioration (associated with injury)

   a. Mechanical ventilation

   b. Sepsis

   c. Single or multiple-organ failure

   d. Major tissue necrosis

CONSIDERATIONS: It is understood that the resources at Trauma Centers of all levels vary, as do the qualifications and credentials of physicians at those respective Centers. Therefore, these criteria serve merely as guidelines for considering transfer and do not necessarily mandate such transfer to a higher-level facility. If the qualifications of the Trauma Surgeon are such that he/she is capable of and trained to manage such complex problems, or if the appropriate specialist is available to manage such injuries (e.g., Orthopedic Surgery), then patients meeting the above criteria may in fact be adequately and appropriately managed at the lower-level Trauma Center.

TRAUMA DIVERSION POLICY

PURPOSE: To establish necessary and sufficient criteria for closing the Emergency Department of a member hospital to trauma.

PRINCIPLE: Trauma care is a round-the-clock operation and is realistically usually required at inconvenient times (e.g., late at night or during times of intense hospital activity). Nevertheless, one of the responsibilities of hospitals participating in the Mississippi Trauma Care System is to be available as often as possible for the unexpected presentation of the acutely injured patient. Criteria for closure must be well delineated and strictly enforced if the Trauma System is to operate efficiently at all times.

GUIDELINES: The following basic guidelines will be adhered to by East-Central Regional member hospitals whenever possible:

1. The Emergency Department at member hospitals shall be "open" to trauma at all times unless otherwise indicated.
2. Beds in any of the Trauma/Critical Care Units or Intensive Care Units shall be allocated in accordance with Allocation Policies established at each individual hospital.
3. If all regular beds in a member hospital are full *and* the Critical Care/Intensive Care Unit is full, then the Emergency Department will be "closed" to trauma and the member hospital

considered to be on “Trauma Diversion” until such time as trauma beds become available. This diversion status will be communicated to the Emergency Department physician on call, the Trauma Director, the Trauma Nurse Coordinator, pre-hospital personnel, and Medical Control for the appropriate EMS District.

4. If, in the opinion of the Trauma Surgeon or Emergency Physician, the resources of the member hospital are currently overwhelmed, then the Emergency Department will be considered “closed” to trauma until such time as the patient load is again manageable in terms of resources available. All such diversions, however, will be closely scrutinized by the Region to assure that trauma patients are not being diverted away from a member hospital for insufficient cause.

REGIONAL RESOURCES/CRITICAL CARE CAPABILITIES

Each member hospital within the East-Central Trauma Care Region must be certified as a Trauma Center at some level. Currently, all member hospitals are Level IV Centers. As a condition of participation within the Mississippi Trauma Care System, each hospital must meet the resource requirements established by the Regulations set forth by the Department of Health. Therefore, each member hospital is expected to maintain capabilities consistent with their respective Trauma Center level; and oversight of these resources is provided by the Department of Health via the certification and review process.

In addition, the East-Central Region has inventoried the resources of each individual member hospital with a concentration on the following areas: 24-hour Emergency Room, ICU, Stepdown/Trauma Critical Care Unit, full-time Trauma Surgeon on staff and available, anesthesia coverage, 24-hour respiratory therapy coverage, 24-hour laboratory coverage, onsite ventilator. These specific parameters were chosen to track because it was felt that the presence or absence of these resources might impact on trauma field triage and diversion, as well as on inter-facility transfer. Resource allocation is summarized in the accompanying chart (see Resource Allocation below).

EAST CENTRAL MISSISSIPPI TRAUMA CARE REGION

RESOURCE ALLOCATION

	NEWTON REGIONAL HOSPITAL	CHOCTAW HEALTH CENTER	NESHOBA CO GENERAL HOSPITAL	ALLIANCE LAIRD HOSPITAL	H.C. WATKINS MEMORIAL HOSPITAL	WINSTON MEDICAL CENTER	RILEY MEMORIAL HOSPITAL
24-Hr. ER	XX	XX	XX	XX	XX	XX	XX
ICU			XX	XX	XX	XX	XX
Stepdown Unit							XX
Full-Time Surgeon			XX				XX
Anesthesia			XX	XX			XX
24-Hr. Resp. Therapy	XX		XX	XX	XX	XX	XX
24-Hr. Lab	XX	XX	XX	XX	XX	XX	XX
Ventilator	XX		XX	XX	XX	XX	XX
Trauma Level	IV	IV	IV	IV	IV	IV	IV

PERFORMANCE IMPROVEMENT

An emphasis on performance improvement is considered essential if the East-Central Trauma Care Region is to successfully carry out its mission of improving trauma care delivery throughout east-central Mississippi. The Performance Improvement effort in the Region has several components: the Trauma Registry, the Performance Improvement process, and educational programs for physicians and nurses.

Trauma Registry

Clearly the most efficient and comprehensive method for collecting data regarding Trauma activity within the Region is the Trauma Registry. This data base contains all concurrent information regarding individual patients as well as any pertinent data regarding protocol violations, delays, or undesirable outcomes. It is expected that each member hospital will use this information to evaluate and correct its own deficiencies and to target areas for further training and/or education. In fact, this is a requirement established by the State for maintaining Trauma Center certification. Such review can and will be done on the regional level as well. All data that falls out of a member hospital's screen for appropriateness of care will eventually be reported to the Region, evaluated and tracked. This type of regional data collection, however, will only become practical and possible when the Regional Trauma Registry is installed. Only with such a system will the Region be able to consistently and reproducibly extract those cases that require review from the large number of cases entered into each individual hospital's Registry.

Performance Improvement Process

The Region has established a performance improvement process to evaluate the effectiveness of the Regional System. The Region has adopted the position that performance improvement is the entire Board's responsibility. Regional Board members will conduct performance improvement activities as part of their regularly scheduled Board meetings. The primary tool for the performance improvement process will be the Regional Trauma Registry designed especially to provide Region-wide data information. Additional topics for performance improvement may include any Regional issues deemed appropriate by the Board.

Educational Programs

Censure and reprimand are certainly not the ultimate goals of a Performance Improvement Plan—*improvement of care delivered* is! To this end, the East-Central Region has placed a heavy emphasis on continuing education at all levels—hospitals, pre-hospital providers, physicians, and nurses. Periodic workshops for pre-hospital providers and for nurses are provided free-of-charge on a variety of Trauma-related topics. In addition, the Region sponsors ATLS training for physicians, ACLS, BTLS, PBTLS, PHTLS, PALS, and PBTLS for all personnel from member hospitals, a Trauma Nurse Core Curriculum Course for nurses from member hospitals (two slots per member hospital per course, the *Journal of Trauma* and the *Journal of Emergency Nursing* subscriptions for each member hospital. All of these services are paid for by the Region and are provided free-of-charge to member hospitals and practitioners as long as those hospitals and individuals remain active members-in-good-standing of the East-Central Region and the Mississippi Trauma Care System.

OUTREACH

Another vital part of the mission of the East-Central Mississippi Trauma Care Region is Outreach. It is the philosophy of the Board of Directors and of the Region as a whole that the only way to effect the development of a truly inclusive state-wide Trauma Care System is by sharing resources with both member hospitals and the lay public alike. To this end, a number of outreach activities and programs have been initiated at several levels to enhance public and physician/nurse education.

Medical Outreach Programs

As discussed at length above, a number of continuing-education programs have been formulated and funded at the Regional level specifically targeting physicians, nurses, and pre-hospital personnel (e.g., ATLS, ACLS, BLS, BTLS, PALS, PBTLS, TNCC). These programs are also being offered to member hospitals and practitioners outside of the East-Central Region as long as those members remain active participants in the Mississippi Trauma Care System. This initial outreach effort was made to the Level IV hospitals, but it is expected that this will be expanded to include other levels as well once increased resources and funds become available. These courses, workshops, and symposia form a major part of the professional educational effort throughout the East-Central Region and, hopefully, throughout the State as well.

Public Information and Education Programs

Education of the lay public with regard to trauma is somewhat more difficult but is equally as important as professional education in terms of improving the quality of care delivered. Specifically, resources cannot be utilized appropriately if the lay public is unaware of the extent of services available in their areas. Therefore, a public information effort has begun within the East-Central Region with the goal of apprising the lay public about the nature and capabilities of the Trauma Centers within their localities. This effort is directed at local newspapers, schools, and civic groups and is an ongoing process. In addition, public education has begun, as distinct from public information. This educational effort is directed toward informing the lay public about such issues as the role and mission of the Mississippi Trauma Care System, the types of injuries which require the resources available at a Trauma Center, the role of the Level IV Centers in each given community, the need and indications for communication between regions and Trauma Centers of different levels, including triage and transfer criteria and protocols. It is also very important that Regional efforts be coordinated with existing public education programs.

Injury Prevention Programs

Although a formal injury prevention program has not yet been started in the East-Central Region, the need for such a program is acknowledged and the groundwork has been laid. Specifically, contact has been made and is ongoing with the Public Education representative from the Department of Health, and plans have been made for her to address the Board regarding the types of resources and programs available through her office. Also, a priority item for the Board agenda in the near future will be the identification of target areas for the injury prevention program. Due to

the scarcity of resources in general throughout the Region and the State, care will be taken not to duplicate programs already in place. It will be beneficial, however, to tie such existing programs to the effort of the East-Central Region so that a larger segment of the population is covered by this effort. The forums for these prevention programs will essentially be the same as those mentioned above: schools, civic groups, and library programs. There are several members of the Regional Board who are already speaking to such groups on a regular basis. The efforts of these individuals will be coordinated in the near future with the efforts of others in the community as well as with the school district in each individual area so that a cohesive, comprehensive program may be established.

REGIONAL BOARD GENERAL POLICIES/BYLAWS

The following formal bylaws have been established and approved by the Board of Directors of the East-Central Mississippi Trauma Care Region (see below):

-Constitution and Bylaws of East-Central Mississippi Trauma Care Region

The following formal policies have been established and approved by the Board.

-Trauma Triage Policy

-Policy for Inter-Hospital Transfer of High-Risk Trauma Patients

-Trauma Diversion Policy

ARTICLE I

Name

The governing body shall be known as the Board of Directors of the East-Central Mississippi Trauma Care Region ("Trauma Region").

ARTICLE II

Purpose and Mission

The purpose and mission of the East-Central Mississippi Trauma Care Region is to provide the citizens of east-central Mississippi with a trauma care system which integrates member facilities within the region and is coordinated with the statewide Trauma System as authorized under Mississippi Code 41-59-1, which coordinates the resources of member facilities, assists member facilities with problem-solving, and distributes grant proceeds made available through the State Board of Health.

ARTICLE III

Board of Directors

Section 1. Membership The membership of the Board of Directors shall be limited to licensed Mississippi hospitals participating in the statewide Trauma System as defined in "The Mississippi Trauma Care System Regulations" established by the Mississippi Trauma Advisory Committee and the State Department of Health, a representative of prehospital Emergency Medical Services providers appointed by the Trauma Region, and the Region's Executive Director, should one be hired. Each participating hospital shall declare, and have certified, a Trauma Center Certification level as defined in the Regulations. The Board shall be comprised of one medical representative and one administrative representative from each member hospital, and one representative of prehospital Emergency Medical Services providers. The latter representative shall be appointed by the East-Central Mississippi Trauma Care Region Board of Directors. Each Board member shall have a single individual vote. Should the Board hire an Executive Director, he/she shall serve as ex-officio member of the Board. All appointments shall be for three years and shall be renewable without term limits. If during that tenure, a Board member dissolves his association with a member hospital—either voluntarily or involuntarily—he will be removed from the Board and replaced by an individual appointed by the individual member hospital to serve out the remainder of the departed Board member's term. The EMS member shall have all rights and privileges as Board members, including voting rights, but shall be ineligible to serve as an officer. Until such time as a permanent Board of Directors is appointed, an Interim Board comprised of interested personnel from potential

member hospitals will be formed to conduct business during the planning phase of establishing the Trauma Region.

Section 2. Meetings The Board of Directors shall hold regular meetings on a quarterly basis, upon fifteen days' notice. The regular meeting in June of each year shall be known as the Annual Meeting. Special meetings may be held at the call of the Chairman, or, in his absence, the Vice-Chairman, or at the call of any four Directors.

Section 3. Quorum At any meeting of the Board of Directors, five Directors shall constitute a quorum for the transaction of business, but less than a quorum may adjourn a meeting to a future time. In the event of a quorum, the action of a majority of the Directors present and voting shall be necessary to bind the entire Board of Directors.

Section 4. Attendance Members of the Board of Directors will be expected to attend all meetings; however, members will be excused from attendance at meetings because of illness, out-of-town business, and other appropriate reasons. Each member may designate another physician, nurse, administrator, or other appropriate person to serve as proxy and to vote in place of the Director in his/her absence.

Section 5. Action Without Meeting The Board may take any action which may be taken at a regular or special meeting of the Board if a consent in writing, setting forth the action so taken, shall be signed and approved by all Directors. If any Director shall dissent to taking action in this manner, no action shall be taken except at a regular or scheduled meeting.

ARTICLE IV

Administration and Management

The Board of Directors may hire such administrative, managerial and clerical personnel as necessary to carry out the functions of the Region. The Board may contract for such services and may authorize the Chairman to enter into contracts therefor. The Board of Directors may establish a fee schedule for membership in the Trauma Region and/or, to the extent permitted by the Mississippi Trauma Care System Regulations, the Board of Directors may allocate a percentage of funds disbursed through the Trauma Region for expenses of the Region's administration and management.

ARTICLE V

Officers

At each Annual Meeting, the Directors shall elect a Chairman, a Vice-Chairman, a Secretary, and a Treasurer, all of whom shall hold office

for a period of one year or until their successors are duly elected. The term of office shall commence on the beginning of the fiscal year, July 1.

ARTICLE VI

Duties of Officers

Section 1. The Chairman of the Board of Directors shall exercise general supervision over all affairs of the Trauma Region; preside at all meetings of the Directors; and, be an ex-officio member of all standing committees and may vote in case of tie votes by such committees.

Section 2. The Vice-Chairman of the Board of Directors shall assist the Chairman in the performance of his duties and, in the absence or inability of the Chairman, the Vice-Chairman shall perform the duties and possess the powers and authority of the Chairman.

Section 3. The Secretary shall keep the minutes of the meetings of the Board of Directors and its standing committees; record the names of all members present at each meeting; and, notify all of the Directors and members of the standing committees at least seven days before the appointed time for meeting, and in such notification, if a special meeting, state the nature of the business for which the meeting is called. The Secretary shall act as Chairman in the absence of the Chairman and Vice-Chairman, and when so acting, shall have all the powers and authority of the Chairman.

Section 4. The Treasurer shall be the custodian of all funds of the Trauma Region. He is responsible to see that the Administration/Management/Contracted Agent of the Trauma Region or other person or entity maintains an accounting system in such a manner as to give a true and

accurate accounting of the financial transactions of the Trauma Region, and he shall make certain that reports of such transactions are presented to the Board of Directors for the determination that all expenditures are made in accordance with state laws and to the best advantage of the Trauma Region.

Note: The use of any gender-specific term in these Bylaws is merely for brevity, and such terms shall be applicable to both genders.

ARTICLE VII

Committees

Following the Annual Meeting, the Chairman of the Board shall appoint the following standing committees whose membership may be from the Board of Directors, the Administrative/Management/Contracted Agent or other competent individuals at member institutions as specified below:

Executive Committee. The Executive Committee shall consist of the Chairman, the Vice-Chairman, Secretary, and Treasurer and shall meet on an ad-hoc basis. In emergency situations, it shall have the power to transact all regular business of the Trauma Region within the determination of the Chairman, when a regular meeting of the Board of Directors is not feasible,

provided that any action taken shall not conflict with the policies and expressed wishes of the Board of Directors at its next regularly scheduled meeting.

Additional Committees. The Chairman of the Board of Directors shall have the power to appoint such other standing or ad-hoc committees using the resources and expertise of the Board of Directors as in the Chairman's discretion may be deemed necessary and proper.

ARTICLE VIII
Conflict of Interest

Section I

Purpose

The purpose of the conflicts of interest policy is to protect the Corporation's interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the corporation. The policy is intended to supplement but not replace any applicable state laws governing conflicts of interest applicable to nonprofit and charitable corporations.

Section II

Definitions

1. Interested Person

Any director, principal officer, or member of a committee with board delegated powers that have a direct or indirect financial interest, as defined below, is an interested person. If a person is an interested person with respect to any entity in the health care system of which the

Corporation is a part, he or she is an interested person with respect to all entities in the health care system.

2. Financial Interest
A person has a financial interest if the person has, directly or indirectly, through business, investment or family--

a. an ownership or investment interest in any entity with which the Corporation has a transaction or arrangement, or
b. a compensation arrangement with the Corporation or with any entity or individual with which the Corporation has a transaction or arrangement, or
c. a potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Corporation is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

A financial interest is not necessarily a conflict of interest. Under Section III, paragraph 2, a person who has a financial interest may have a conflict of interest only if the appropriate board or committee decides that a conflict of interest exists.

Section III

Procedures

1. Duty to Disclose

In connection with any actual or possible conflicts of interest, an interested person must disclose the existence of his or her financial interest and must be given the opportunity to disclose all material facts to the directors and members of committees with board delegated powers considering the proposed transaction or arrangement.

2. Determining Whether a Conflict of Interest Exists

After disclosure of the financial interest and all material facts, and after any

discussion with the interested person, he/she shall leave the board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

3. Procedures for Addressing the Conflict of Interest

    a. An interested person may make a presentation at the board or committee meeting, but after such presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement that results in the conflict of interest.

    b. The chairperson of the board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

    c. After exercising due diligence, the board or committee shall determine whether the Corporation can obtain a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest.

    d. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the Corporation's best interest and for its own benefit and whether the transaction is fair and reasonable to the Corporation and shall make its decision as to whether to enter into the transaction or arrangement in conformity with such determination.

4. Violations of the Conflicts of Interest Policy

    a. If the board or committee has reasonable cause to believe that a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.

    b. If, after hearing the response of the member and making such further investigation as may be warranted in the circumstances, the board or committee determines that the member has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Section IV

Records of Proceedings

The minutes of the board and all committee with board-delegated powers shall contain—

1. the names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the board's or committee's decision as to whether a conflict of interest in fact existed.

2. the names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection therewith.

Section V
Compensation

1. A voting member of the board of directors who receives a compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation.

2. A physician who is a voting member of the board of directors and receives compensation, directly or indirectly, from the Corporation for services is precluded from discussing and voting on matters pertaining to that member's and other physicians' compensation. No physician or physician director, either individually or collectively, is prohibited from providing information to the board of directors regarding physician compensation.

3. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation.

4. Physicians who receive compensation, directly or indirectly, from the Corporation, whether as employees or independent contractors, are precluded from membership on any committee whose jurisdiction includes compensation matters. No physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.

Section VI

Annual Statements

Each director, principal officer and member of a committee with board delegated powers shall annually sign a statement, which affirms that such person—

a. has received a copy of the conflicts of interest policy,

b. has read and understands the policy,

c. has agreed to comply with the policy, and

d. understands that the Corporation is a charitable organization and that in order to maintain its federal tax exemption it must engage primarily in activities, which accomplish one or more of its tax-exempt purposes.

Section VII

Periodic Reviews

To ensure that the Corporation operates in a manner consistent with its charitable purposes and that it does not engage in activities that could jeopardize its status as an organization exempt from federal income tax, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

a. Whether compensation arrangements and benefits are reasonable and are

the result of arm's-length bargaining.

b. Whether acquisitions of physician practices and other provider services result in inurement or impermissible private benefit.

c. Whether partnership and joint venture arrangements and arrangements with management service organizations and physician hospital organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.

d. Whether agreement to provide health care and agreements with other health care providers, employees, and third party payers further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.

Section VIII

Use of Outside Experts

In conducting the periodic reviews provided for in Section VII, the Corporation may, but need not, use outside advisors. If outside experts are used there use shall not relieve the board of its responsibility for ensuring that periodic reviews are conducted.

ARTICLE IX

Disposition of Assets Upon Dissolution

Upon the dissolution of the East-Central Mississippi Trauma Care Region, all of its assets shall thereupon become the property of and inure to the benefit of the State of Mississippi, State Department of Health, and no part thereof shall inure to the benefit of any member hospital or of any individual.

ARTICLES OF INCORPORATION

A. The purposes for which the (corporation) East Central Mississippi Trauma Care Region is organized are exclusively religious, charitable, scientific, literary and educational within the meaning of Section 501 c (3) of the Internal Revenue Code of 1986 or the corresponding provision of any future U.S. Internal Revenue law.

B. Notwithstanding any other provision of these articles, this organization shall not carry on any activities not permitted to be carried on by an organization exempt from federal income tax under Section 501 c (3) of the Internal Revenue Code of 1986 or the corresponding provision of any future U.S. Internal Revenue Law.

C. In the event of dissolution, the residual assets of the organization will be turned over to one or more organizations described in Sections 501 c (3) and 170 c (2) of the Internal Revenue Code of 1986 or corresponding sections of any prior of future Internal Revenue Code, of the federal, state, or local government for exclusive public purpose.

D. No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments distributions in furtherance of the purposes set forth in paragraph A hereof. No substantial part of the activities of the corporation shall be carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or

distribution of statement) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under section 501 c (3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or (b) by a corporation, contributions to which are deductible under section 170 c (2) of the Internal Revenue Code, or the corresponding section of any future federal tax code.